

EXHIBIT 85

RETAIL PHARMACY QUESTIONNAIRE

Servicing Distributions Center(s) _____

Name / Phone Number of BDM or Account Manager: _____

This questionnaire is to be completed by the Owner and Business Development Person during an on-site visit

1. Pharmacy Name: _____

- ABC Account number _____
- Pharmacy's dba (doing business as), if any _____
- Has the pharmacy ever operated under a different name?
Yes _____ No _____ If yes, provide the Name:

Mandatory – Form will not be processed unless “D” and “E” are answered:

- Will ABC be this customer's primary wholesaler? Yes _____ No _____
- Has this customer signed a Prime Vendor agreement? Yes _____ No _____

2. Pharmacy Address: _____

- City _____
- State _____
- Zip _____

3. Pharmacy Phone Number: _____ Fax Number: _____

4. Pharmacy Email Address: _____

5. Check one:

Start-up business. Other suppliers _____
 Existing business adding or changing suppliers. Current/prior supplier(s) _____

If changing supplier(s), why? _____

Existing ABC Customer. Account # _____

- Has been customer of ABC: Years _____ Months _____
- Customer's current ratio of CS to Non-CS invoice lines % _____
- Customer's total monthly dollar purchase volume w/ABC _____

6. Name of pharmacist –in –charge (PIC) as it appears on the license

7. PIC's state license number: _____

8. Has the PIC ever been sanctioned/disciplined in any state(s) where they are or have been licensed?
Yes _____ No _____ If Yes, give details (when, why, etc.)

9. Is this pharmacy affiliated with any other pharmacy?

Yes _____ No _____ If yes, provide the following:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Note: If there are additional affiliates please attach an additional sheet with the information

10. Ownership type: Check one

a. Sole Proprietor _____ Corporation _____ Partnership _____
 Other _____ (describe)
 a. If corporation, state of incorporation _____
 b. If corporation, Chief Executive Officer _____

11. Owner(s) name: _____

a. Owner's dba (doing business as), if any _____

12. Owner Business Address: _____

13. Owner Phone Number: _____ Fax Number: _____

14. Owner Email Address: _____

15. Number of years owner has operated pharmacy _____

16. Is the Owner a licensed pharmacist?

Yes _____ No _____

17. Pharmacy DEA registration #: _____

18. State BOP license #: _____

19. Has a supplier ever suspended or ceased controlled substance sales to the pharmacy? _____ Yes _____ No _____
 If yes, why? _____

20. Has the Pharmacy ever had a DEA registration suspended or revoked?

Yes _____ No _____ If so, give details (when, why, etc.)

21. Has the Owner, family member, or any employee of the pharmacy ever had a DEA registration suspended or revoked?

Yes _____ No _____ If so, give details (when, why, etc.)

22. Does the pharmacy have any other licensure/registration (wholesale, repackager, etc...)?

Yes _____ No _____ If so, provide copies.

23. Is the pharmacy a "specialty" pharmacy?

Yes _____ No _____ If yes, describe _____

24. What percentage of the following describes the pharmacy's business activities?

____ % Retail
 ____ % Long Term Care
 ____ % Compounding
 ____ % Infusion
 ____ % Other (explain) _____

25. Check the following manners of receiving business and provide what percentage of the total business it comprises:

Walk-In	Yes _____	No _____	____ %
Phone	Yes _____	No _____	____ %
Fax	Yes _____	No _____	____ %
Internet/Mail Order	Yes _____	No _____	____ %

26. Which state(s) does the pharmacy ship into (if any)? _____

27. Is the pharmacy licensed for sales in all states it distributes to?
 Yes _____ No _____

28. Are all prescriptions written by physicians located in the state in which the patient resides?
 Yes _____ No _____

29. Does the pharmacy have written policies and procedures regarding the filling of prescriptions?
 _____ Yes _____ No If yes, attach pertinent sections.

a. How many prescriptions are filled daily _____; monthly _____ ?

b. Percentage of prescriptions that are controlled substances _____ %

c. Verification process _____

d. Does the pharmacy use the State Rx monitoring program? _____ Yes _____ No _____ N/A

e. Does the pharmacy verify the physician's state license and/or DEA registration? _____ Yes _____ No

f. Does the pharmacy engage in discussions with prescribing physicians? _____ Yes _____ No If yes, how documented? _____

g. What is the pharmacy's procedure for reporting fraudulent Rx's? _____

30. Check the following types of products and provide the approximate percentage of products you expect to purchase from AmerisourceBergen?

HBA/OTC	Yes _____	No _____ % of total purchases
Non-Controlled Rx	Yes _____	No _____ % of total purchases
Controlled Substances	Yes _____	No _____ % of total purchases
Listed Chemicals	Yes _____	No _____ % of total purchases

31. Anticipated or actual usage of certain controlled substances:

Item	Monthly Usage	Average Tablets per Prescription	Average Days Supply per Prescription
Oxycodone Combination Products			
Hydrocodone Combination Products			
Methadone			
Alprazolam			
Prometh w/Codeine	(1 pint bottles)	N/A	

List high prescribing physicians and their DEA registrations for the above products. Attach an additional sheet if necessary: _____

32. Does the pharmacy have a web site?
 Yes _____ No _____ If yes, provide web address(es): _____

Note: If no, you are required to notify us immediately upon establishing a web site.

33. Is the pharmacy affiliated with a web site?

Yes No If yes, provide web address(es):

Note: If no, you are required to notify us immediately upon affiliating with a web site.

34. Will the pharmacy download and fill prescriptions on a per prescription fee basis from a website for dispensing?

Yes No If yes, provide web address(es):

35. Check the following types of payments the pharmacy receives for products and provide the approximate percentage of total payments:

Private Insurance	Yes <input type="checkbox"/>	No <input type="checkbox"/> % of revenue
Medicare/Medicaid	Yes <input type="checkbox"/>	No <input type="checkbox"/> % of revenue
Cash	Yes <input type="checkbox"/>	No <input type="checkbox"/> % of revenue
Other	Yes <input type="checkbox"/>	No <input type="checkbox"/> % of revenue

If other, provide details _____

36. Attach and date photographs of pharmacy building (2 of inside, including counter area & 2 of outside-front and back of pharmacy).

OTHER COMMENTS/OBSERVATIONS:

I, as the Owner or [authorized representative or officer of the Owner], declare that I have completed this Retail Pharmacy Questionnaire and to the best of my knowledge and belief the information provided is true, correct and complete.

OWNER:

Name of Entity/Person

By: _____

Name: _____

Title: _____

Date: _____

I, as the authorized AmerisourceBergen representative, declare that I have reviewed this Retail Pharmacy Questionnaire with the owner or [authorized representative or officer of Owner] and to the best of my knowledge and belief the information provided is true, correct and complete. **I therefore recommend opening this account.**

AMERISOURCEBERGEN ASSOCIATE:

AMERISOURCEBERGEN REGIONAL VP

Signature _____

Signature _____

Full Name (Print) _____

Full Name (Print) _____

Title _____

Cell Phone Number _____